

Assisting with SSI/SSDI Applications

Case Study of a Program to Help Clients of a Homeless Shelter and Supportive Housing Residence with SSI/SSDI Applications

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Background

The high prevalence of physical and psychiatric disabilities among chronically homeless individuals is well-established, with many facing significant and permanent barriers to gainful employment (Burt, 1999; O’Toole, Gibbon, Seltzer, Hanusa & Fine, 2003; National Coalition for the Homeless, 2009). Homeless individuals with health and mental health conditions face numerous structural barriers establishing or re-establishing public benefits they may be entitled to, including Supplemental Security Income (SSI). Additionally, the homeless are more likely than non-homeless to be denied for SSI based upon an incomplete or insufficient consultative examinations offered by representatives from the Social Security Administration (SSA) (O’Connell, Quick & Zevin, 2004). Approximately 29 percent of adult SSI claims are approved, while homeless individuals are approved at about half that rate – despite their potentially higher likelihood to qualify for such benefits (Rosen, Hoey & Steed, 2001; Social Security Advisory Board, 2006; Kauff, Brown, Altshuler, Denny-Brown, & Martin, 2009).

A national trend in homeless services is the Housing First model which prioritizes the housing of chronically homeless individuals regardless of sobriety or other barriers which can prevent immediate housing (Tsemberis, 1999; Padgett, Gulcur & Tsemberis, 2006). This approach varies, but frequently includes a focus on access to benefits for these individuals, including General Assistance, food stamps, SSI, Social Security Disability Insurance (SSDI) and veterans benefits (O’Hara, 2007; Burt, Wilkins & Mauch, 2011). Certain strategies to improve access have been identified. A national review of community approaches to assist the homeless in accessing mainstream benefits found the relevance of enhanced communication between entitlement program representatives and homeless advocates, as well as the co-location of benefits’ representatives in various settings (Burt et al., 2010). The federal SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative is another model to consider. Among other strategies, SOAR provides specialized trainings regarding SSI/SSDI applications to case managers from nonprofit and governmental organizations (Kauff et al., 2009).

Many of these strategies rely heavily on case managers and social workers to facilitate the SSI/SSDI application process. While these individuals are crucial partners in the application process, many programs have faced challenges. For example, one-large scale evaluation found that many participating case managers identified not having the time, capacity and full knowledge to help prepare SSI/SSDI applications; case managers were more successful when their sole responsibility was to help clients navigate the SSI/SSDI process (Kauff et al., 2009). A smaller experimental study of a social work-based intervention in New York City to help improve entitlement receipt identified that social workers were able to improve receipt of benefits such as food stamps, but had little impact on SSI receipt (Nuttbrock, Rosenblum, Magura & McQuiston, 2002). Challenges can be attributed, in part, to the “cumbersome [SSI] application process” where the application is complex, with significant time investments and insight required to fully complete it (Burt et al., p. 90, 2010; Health Consumer Alliance, 2010; Stone, 1984; Keiser, 1993).

A small but growing number of nonprofit organizations have provided legal experts in supportive housing and shelter settings to assist with benefits applications (Burt et al., 2010; Rosenheck, Frisman & Kaspro, 1999). One typical approach to legal benefits application assistance is a drop-in clinic where clients can obtain advice; another common approach involves legal trainings for case management staff (Burt et al., 2010). Additionally, many service providers across the country have received training and technical assistance via SOAR; states which received SOAR assistance had more successful aggregate outcomes for their homeless individuals obtaining SSI/SSDI benefits (Dennis, Lassiter, Connelly & Lupfer, 2011).

In November 2009, a public interest nonprofit law center offered a program (the Program) which co-located lawyers and paralegals first in a drop-in shelter and then eventually near a supportive housing setting. These legal professionals intended to serve as the SSI/SSDI application coordinators over the duration of the application. This case study researched the implementation of the Program as one attempt to help homeless and recently homeless individuals obtain SSI/SSDI benefits. This study expands upon and enriches emerging data about attempts by human service organizations to engage homeless individuals in the SSI/SSDI benefit application process. The study identifies barriers and facilitators to implementation, as well as the particular dynamics of helping this client population obtain SSI/SSDI benefits.

Research Design

The aim of this study was to produce an in-depth description of the Program, identify both barriers and facilitators to the implementation of the Program, and analyze Program processes via a case study. A case study is one appropriate research approach to better understand the processes and dynamics of a program or intervention (Yin, 2003). Data was utilized from two sources: interviews with stakeholders and Program documents. The study was approved by the UCLA Institutional Review Board.

Interviews with Organizational Stakeholders

The study population in this case study were stakeholders connected to the Program. Individuals from key organizations were pursued: the law center administering the Program, a drop-in homeless shelter (the Shelter), the Supportive Housing Organization (SHO) and the Social Security Administration (SSA) field office where most client cases connected to the Program were filed.

A total of fourteen one-on-one semi-structured interviews were conducted by the author. All interviews were conducted in person, with the exception of two conducted via telephone. All interviews were approximately one hour. Numerous attempts were made to reach representatives from the Shelter, without success. The professional roles of the respondents included: senior administrators, senior staff attorneys, staff attorneys, and paralegals from the law center (n=8); senior administrators, supervising social workers and case managers from the SHO (n=4); and SSA administrators (n=2). Interviews were recorded and professionally transcribed.

Domains covered in the interview guide included the history of developing the Program, the application process, the communication and coordination between various stakeholders, perceived barriers and facilitators to implementation of the Program as envisioned and future plans. An emergent domain included the specific challenge of working with homeless and formerly homeless clients.

Respondents were identified in three ways. First, all individuals working with the Program at the time of data collection were recruited to be interviewed via direct request by the author (n=3). These individuals were then asked to nominate other individuals connected to the Program, as well as external stakeholders from the three organizations described above. A total of nine respondents were identified through this method. These respondents received an introduction email from the Director of the Program. The author then emailed and/or called all nominated individuals. The third way respondents were identified was if, over the course of an interview, a previously unidentified individual was mentioned as relevant to the understanding of the Program (n=2). In those cases, the author directly contacted that individual.

To verify connection to the Program, all recruited individuals were asked:

1. Are you familiar with the [law center's] SSI/SSDI Program?

2. Have you been involved in the [law center's] SSI/SSDI Program in any way? (This includes communication such as email, telephone and in-person informal or formal meetings.)

If a respondent answered yes to both questions, they were pursued for an interview. All respondents were not told who else had been approached or agreed to participate in the study in order to protect identities. All respondents went through the informed consent process.

Program Documents

The author was provided formal Program documents including grant applications, grant reports and various forms used by the Program.

Data Analysis

Interview transcripts and Program documents were analyzed thematically using Atlas.ti[®] qualitative software as a data management tool (ATLAS.ti GmbH, Berlin, Germany, version 6.2). The qualitative data was analyzed using directed content analysis (Hsieh & Shannon, 2005). Directed content analysis entails a goal of “validat[ing] or extend[ing] conceptually a theoretical framework or theory” (Hsieh & Shannon, 2005, p. 1281). In this case, the study is primarily influenced by a theoretical framework that identifies structural barriers as hindering benefits receipt. A directed content analysis allows for pre-identified domains to be covered in the interviews and data analysis, as well as iterative ideas and concerns to emerge over the course of the research. After each interview, a memo was produced order to capture immediate reactions and ideas (Miles & Huberman, 1994).

Respondents were divided into categories as “Administrators” (n=7) and “Client Providers” (n=7). Due to the small sample interviewed, respondents are identified by these labels with a corresponding ID number to help protect respondent identities. While these two categories do not sufficiently describe the roles of respondents, they provide a limited description of their responsibilities.

Findings

1. Initial development of Program, including formal objectives

Beginning in late 2009, the Program was offered twice a week for clients of an emergency drop-in overnight shelter (the Shelter), initially embedding two attorneys in this setting. The original stated objectives of the Program were threefold as identified in grant materials: 1) to ensure that shelter residents be assisted with applications for food stamps and general assistance (i.e., cash welfare benefits for adults without dependents); 2) develop a stronger and formalized liaison with the Social Security Administration to facilitate efficient processing of SSI/SSDI applications and 3) connect shelter residents with permanent supportive housing that could be sustained by their SSI/SSDI or veterans benefits. According to several respondents, the original impetus for the program emerged via a local politician's concern about homelessness in their district. The program was eventually funded by city and private monies. Both grants emphasized the overall objective of getting homeless people housed.

In 2010, the Program transitioned to a new setting and partnered with a second nonprofit organization to accommodate several barriers to implementation, described below. The second organization was a provider of permanent supportive housing for chronically homeless individuals, most with serious mental illness (Supportive Housing Organization or SHO). The Program was provided office space in one of the buildings owned by the SHO, geographically close to residents. After the move to the second setting, the staffing varied to include another attorney, a paralegal, an administrative assistant and undergraduate

volunteers at various times in the Program's operations. The Directing Attorney was consistently with the Program from its inception.

2. Perceived barriers to initial implementation

a. Multiple objectives, conflicting objectives

A barrier to program implementation involved the original three objectives of the Program, described above. While the second objective of developing a formal liaison with the SSA was established soon after the Program began, the first and third objectives faced different challenges. The first objective of enrolling clients in food stamps and general assistance was found to be unnecessary as most clients were already receiving these benefits, if eligible. The third objective regarding housing assistance proved to be a challenge for the Program, as locating and securing housing were not main competencies of the Center.

We had skills that could benefit the [Shelter] clients. We didn't particularly have the housing skills. We were not housing experts. We were legal experts who could help with disability applications and overcome the tremendous hurdles that clients face when they're seeking disability benefits. 1.7, Client Provider

Respondents from the Program also expressed the material concern of a lack of housing:

The thing is, there wasn't any housing available anyway. In general, there's a dearth of affordable supportive housing in [the city]. What was available is usually for elderly people or women with children. And most people in the shelter are not in those two categories. 1.5, Administrator

The objective toward obtaining housing for clients by the Program was also complicated by the fact that the Shelter staff focused on locating housing for Shelter clients, as well. The result was Program staff inadvertently competing rather than collaborating with the Shelter staff in regards to housing assistance.

There were two housing people at [the Shelter] who just did housing and so they were already there too which made it also kind of unclear what our role was. And so we tried to work with them and collaborate, but when there's so little housing and some people have the connections already, they just use those connections to get their people into housing. 1.5, Administrator

b. Barrier: Drop-in homeless shelter setting

Assisting with SSI/SSDI applications eventually became a goal that the Program focused on within the Shelter. However, respondents from the Program discussed the stressful environment of the Shelter as a barrier to assisting with SSI/SSDI applications.

Once we met with the case managers [at the Shelter], most of them were very willing to work with us and to make the referrals. But they have really stressful jobs working in the shelter. And they also were under these kind of orders...to get a certain number of people out of the shelter and placed into housing every week or they lose their jobs. And so there was that threat all the time. And so evaluating people for us wasn't necessarily their priority. They were more focused on just dealing with the crisis of the day and then getting people out of the shelter into some kind of transitional housing. 1.5, Administrator

The drop-in shelter also did not have the resources that respondents identified as vital to being able to process and manage SSI/ SSDI applications. For instance, the shelter was not able to provide internet or phone service and had a “strictly-rationed photocopier” – all resources which were identified as very important to the application process (1.1, Client Provider). Finally, all respondents who had had involvement with the Shelter identified a barrier regarding basic access to clients.

Emergency shelters don't let people stay there during the day! They bus them all out at first thing in the morning...So what we worked out was that [the other lawyer] and I would go two mornings a week from eight till noon. And, anybody who wanted to see us would have signed up the night before with the case managers. And then they could stay behind the next morning when the buses took everybody out. They could stay behind and hang around. And then meet with us. And that proved to be difficult for a lot of reasons. If they stayed behind and met with one of us at 8 o'clock -- then they're stuck there all day...And many, many clients would forget. And off they would go the next morning...[Or]many of them needed to come see us but they hadn't stayed at the shelter the night before, so they're not allowed in the next morning during the day. People couldn't just come see us if they needed to. Or come find us...So it just was not working well at all. 1.1, Client Provider

3. Program adaptation via collaboration

After an approximate six month period of embedding the Program in the Shelter with various programmatic challenges, the Program moved to the second setting into property leased by the SHO. The SHO was readily available in the service environment, with resources including office space. At this point, the primary *activity* of the Program became the preparation and management of SSI/SSDI applications. Respondents from the Program identified a turning point via the different setting near the SHO.

Basically we realized [the Shelter] is not a good environment for us to work out of. So let's regroup and figure out a more strategic setting, and ultimately [the SHO] turned out to be ideal. So it all worked out for the better. 1.4, Administrator

The Program continued to see any clients referred from the Shelter, but they now were referred more stabilized and available clients living in housing maintained by the SHO as compared to the Shelter. The SHO was interested in getting their clients onto SSI/SSDI for a variety of reasons, including a more stable income for their clients and the automatic awarding of Medicaid with an SSI/SSDI award.

Respondents from the SHO also described a gap filled by the Program. Prior to the Program, they occasionally had external organizations assist with SSI/SSDI applications with primarily social workers assisting with applications. One respondent perceived the knowledge proffered via the legal background of the Program staff as important:

I work with benefits advocates that have been good at what they did, absolutely and had great interviewing skills with clients because they had social work backgrounds and case management backgrounds. But I think having an attorney was really helpful. I would say that, absolutely. A [Program staff person] was just such a wealth of knowledge. 2.2, Client Provider

The new location of the Program was also now geographically near the clients living in supportive housing arrangements. This location was also close to clients who stayed in the Shelter: this

area was where clients would congregate during the day before being bussed back to the drop-in homeless shelter. The proximity and access to clients was perceived as a key facilitator.

When we moved locations, we moved out of meeting at [the Shelter] at the conference room to the new set up where our clients could just find us. They could drop in on us. We were accessible...Right near the [SHO] office, just a block away. If they disappeared for awhile from the [Shelter], they could find us there. Whereas, at the shelter they couldn't just drop in. 1.5 Client Provider

So by having an onsite presence in proximity to where they've been able to house individuals, who have a long history of homelessness and being on the streets, coupled with mental disability, and getting to familiarize them with their legal services and advocacy groups that are friendly, and that are there for them has a unique opportunity to enable us to do the work more effectively. We can help by managing their documentation, maintaining contact with them, ensuring that they make their appointments, make the interviews that are necessary for the application for SSI. 1.4, Administrator

Interestingly, a Respondent from the SHO (2.2, Client Provider) also indicated that they were grateful that the Program's staff seemed so "self sufficient" and levied few requests such as ordering medical records for clients as other benefits advocates had done in the past.

4. Clients as complex resources

Clients were important resources to the Program – without clients, there would be no Program. As described, clients served by the Program were either from the Shelter or they resided in the apartments maintained by the SHO. All clients in the SHO were defined under federal law as chronically homeless. In the words of one respondent, almost all clients also had some type of serious mental health challenge. The interviews suggested that the challenges presented by the client population influenced programmatic decisions. For instance, respondents involved in the Program's operations discussed mechanisms to test out whether a client would be both capable and interested in pursuing a claim for SSI/SSDI.

[After the first visit], we would ask them to come back in a week or two to start a more in-depth questioning process. There is a tremendous amount of information you have to gather. To fill out all the forms. Some people we would lose right after that. [At the first visit], we wouldn't start ordering medical records. Which is something that needs to be done soon. But we learned not to do it after the first meeting and have clients sign release forms and all that because many of them we would never see again. So then at the second meeting, we would start the in-depth questioning process and we would begin with a section about their medical history and their medical treatment and so forth. And after that meeting is when we would request the medical records. 1.1, Client Provider

Another respondent who worked in the clinic discussed how, despite their mechanism to test clients' capacity and interest in returning, some would not return after investments toward the application were made.

My instinct is to hurry and get things done as soon as possible. But the strategy that we take at the clinic is to have a long initial meeting, and then another follow-up meeting to see whether the clients can be relied on to return. And then at that point, potentially take the next step of requesting medical records. And then seeing from there whether the medical records support immediate filing of an initial claim or an appeal...I think it works well because it saves us time and energy from requesting

and reviewing medical records, and then having the client not show up. The flip side is that it's another amount of time that they're waiting...Even this tactic [of waiting until the second visit to order records] doesn't save us the entire problem. There are plenty of times when we take steps, and then the person doesn't show up again. 1.2, Client Provider

While characteristics of the clients affected their ability to participate in the application process, many respondents from the Program and the SHO identified how important it was for staff to positively engage clients so they would return for the multiple visits required to work on their SSI/SSDI application, as well as divulge sensitive medical histories. Several respondents suggested that clients would not return if they did not feel comfortable.

Most of the people that come in do have mental disabilities. And so we're getting like really in-depth with that stuff...They have to feel comfortable sharing that stuff. Because they might not realize that a certain detail like that is important. They're like, "well why do you need to know about whatever?". And it's like, "well, we do". 1.8, Client Provider

Respondents from the SHO suggested the staff and environment were positive and flexible, thus encouraging the clients they referred to the Program to stay engaged.

I realized how helpful they are there with really working with our types of residents and understanding of what is hard for them. And really, really just working with them and being flexible and not being like, "Oh, you missed an appointment. We're going to drop your case." But they try to help everyone. 2.4, Client Provider

Respondents from the Program also suggested that sometimes clients did not return immediately, but if they returned at all, their application would be considered.

Whether or not clients persisted in returning for appointments, the interpretation of the medical records would also determine whether the application would be filed for a client.

We did prefer to review the medical records before we decided to file, help them file the claim or not...And of course, we are lay people. But you learn after awhile that with the medical records they have, the treatment records they have, the conditions they say that they have with their work history and their education - there is virtually no way they are going to be found disabled. Or they have no treatment at all yet or something like that. It's like way too early in a lot of cases. Or completely unsupported. And we're not going step in to one of those things and spend 40, 50 hours on a case for someone. So we did tell them that up front. 1.1, Client Provider

One respondent from the Program viewed the Program's role as helping to assure quality applications for the Social Security Administration which included identifying the disabled from those who were not.

We want folks to get the help they need. We also don't want people who don't deserve the help to defraud the system. You know, we're only interested in helping people that we think have legitimate claims, because they are profoundly disabled. Otherwise we're not going serve them. And that's an asset to [SSA], and I think the quality assurance piece. 1.4, Administrator

While the medical records helped determine whether an application would be filed by the Program, caseworkers from the SHO would also help determine referrals to apply for SSI/SSDI based on impressions of disability and inability to work.

I guess anyone really could [be referred], but I usually send my clients who I feel are a little bit lost and I can tell that they definitely have whatever their mental diagnosis is. I can tell, “okay yeah, you’re definitely very depressed and could not keep a job or are schizophrenic and could not keep a job. But you’re only on GR and you should be getting more than that because I know you’re never going to be able to get a job.” So it’s like I guess anyone with a diagnosis could try to get SSI, but I definitely tend to lean more toward my clients where I feel like they’re kind of lost and not very aware. There are some people who have a diagnosis but they’ll still go work somewhere part time...I mean I’m sure they could still get on SSI, but in my mind I guess I have a little bit of a feeling of the people that really deserve to be on SSI are the ones who truly could not hold a job. 2.4, Client Provider

Even though Program and the SHO staff exercised discretion in various areas, many noted the Program’s willingness to assist certain categories of clients that other programs do not consider. For instance, one respondent suggested that few organizations help with initial applications (1.8, Client Provider). Another respondent from the SHO suggested that another similar program in the community was more limiting in who they served by only assisting clients who had just recently become housed after being chronically homeless. The Respondent noted that the Program assisted any clients referred from the SHO, despite how long they had been in supportive housing (2.3, Administrator).

5. Missing medical provider as barrier in both settings

The most frequently mentioned barrier to assisting clients with SSI/SSDI applications in both settings was the lack of a designated medical provider or service to evaluate and treat clients. In the initial setting at the Shelter, the medical provider was absent.

To have a successful SSI application, you really need to have a medical partner to help you get medical records. First of all, someone that’s treating the patients on a regular basis because a lot of the individuals were going to apply based on mental health needs. And so for that, you’ve got to show...like 9 to 12 months of consistent treatment to be successful in your application. So we really needed that connection and this man was supposedly a psychiatrist who is there on-site [at the Shelter]. And he was never around. He didn’t see people. 1.5, Client Provider

After the move to the second setting with a new set of clients, a similar need for a medical provider or medical service continued. Respondents from the Program – with law backgrounds – described attempts to learn medical terminology to assist with SSI/SSDI applications.

I spent a lot of time in my first few months just reading stacks and stacks of medical records and trying to make sense of them, and Googling the terms and Googling the abbreviations and Googling basically everything. And then trying to make sense of what the condition was...So that was, I think, the biggest challenge, is that we’re trying to make medical determinations. We need someone to say, “yes, this person has a really bad medical condition”, and then we follow through the legal part of it. But the front end is so labor intensive, trying to understand their conditions. 1.2, Client Provider

The real challenge with the mentally ill is diagnosing their disability, which is often times masked by addiction of some sort. So you have to have the expertise to wade through that. If we had a highly dedicated psychiatrist or psychologist who could do the documentation on the mental health records that we need...this would take this project up to a whole new scale. 1.4, Administrator

There was also a stated concern about the need for costly specialized tests to help diagnose certain disabilities.

Sometimes clients could use specialized evaluations or specialized testing such as psych testing, cognitive testing. It's not ordinarily provided in the indigent healthcare system. Intelligence testing. Things of that sort. You can't get that kind of thing done for free. 1.1, Client Provider

Discussion / implications

Securing SSI/SSDI benefits for disabled homeless individuals is a stated priority of many local and national governmental and non-governmental entities (Health Consumer Alliance, 2010). This case study suggested that assisting clients with their SSI/SSDI applications in the setting of a drop-in homeless shelter was near impossible. The Shelter closing during the work day preventing access to clients and the lack of basic office resources were cited as barriers to the Program. While the author could not locate statistics regarding the prevalence of these arrangements in shelters nationally (e.g., closing during the day), conversations with experts have suggested this is common practice (Leslie Wise, personal communication, March 1, 2013). Perhaps most importantly, the staff of the Shelter were not meaningfully incentivized to have their clients obtain SSI/SSDI benefits and thus were at odds with the Program staff. Therefore, a shelter may not be an appropriate setting for this type of work. It should be noted that a small number of clients originally from the Shelter had their applications processed by the Program *after* the Program moved to the SHO setting and were able to access the Program during the day.

The fact that the Program could more adequately serve clients who were already housed is important. In some ways, this serves as justification of the Housing First model which supports the idea that housing needs to come before all other concerns or needs of a homeless individual can be adequately addressed (Padgett, Gulcur, & Tsemberis, 2006). This case study can be instructive to other organizations with Housing First models seeking to improve access to SSI/SSDI benefits for their residents. One clear challenge is mobilizing the multiple competencies and partnerships needed to successfully complete or appeal these applications: in this case, the missing component seemed to be a medical partnership.

A related lesson from this case study involves the nature of adaptation and collaboration. The Program needed to adapt by narrowing their Program objectives and by finding another organization to partner with. The multiple objectives appeared to have been developed, in part, as a response to the resource environment which emphasized housing needs of homeless. This experience is common to human service organizations, often framed via a political economy perspective which must account for its external resource environment to survive (Cress & Snow, 1996; Garrow & Hasenfeld, 2010). The Program, in this case, was able to adapt its activities to focus primarily on the pursuit of SSI/SSDI applications. (One aspect of this adaptation involved the flexibility by the funding organizations to accommodate the Program). Lessons from the collaboration also suggested mutually beneficial goals identified between the Program and the SHO. Comments from respondents with the SHO suggested that what worked well compared to prior collaborations around benefits assistance was that the Program was able to be relatively self sufficient in its work.

There should be little surprise that this case study revealed discretion being exercised at the Program level in regards to identifying which clients should receive scarce resources of staff time and Program funds (e.g., costs to obtain medical records). In fact, the exercise of discretion in this context was a necessary aspect of programmatic functioning or the program could not be sustained. This discretion occurred at the referral process by the SHO and again in the Program setting via mechanisms such as identifying whether clients could keep medical appointments and/or had the medical records to justify a claim. The clients' capacity to be involved in the lengthy application or appeal process serves as a

particular irony – clients who are so profoundly disabled as to hinder their ability to participate are unable to access SSI/SSDI and yet clients need to meet a particular threshold of documented disability in order to be appropriate clients for the Program. The Program and the SHO also identified the need for the Program to be flexible and compassionate with this population so they would be encouraged to return and divulge challenging health histories. In this way, clients served as complex resources to the Program.

Limitations

There are many limitations to this study. The inclusion of other organizations and programs would have allowed for a basis of comparison with this program. The relatively few number of respondents from the SHO and the Social Security Administration hinders triangulation. The study would have been strengthened by having other individuals participate in the data analysis to strengthen analysis. The study would also have been strengthened by including observations of client / staff interactions and organizational interactions (i.e. between the Program staff and the Shelter and SHO). While not the focus of the program, the author did not collect data regarding quantitative outcome measures such as SSI/SSDI application approval rates. Another crucial limitation of this study is that shelter staff did not participate in the interviews, despite numerous attempts to schedule them.

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